DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-11

RATE FILING SUBMISSIONS FOR HEALTH INSURANCE, LIMITED BENEFIT PLANS, EXCESS LOSS INSURANCE, SICKNESS AND ACCIDENT INSURANCE, OTHER THAN HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the commissioner of Insurance under the authority of §§ 10-1-109, 10-3-1110, 10 16-107, 10-16-109, and 10-18-105(2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to ensure that health insurance rates on limited benefit plans, excess loss Insurance, sickness, and accident insurance, other than health benefit plans, are not excessive, inadequate or unfairly discriminatory, by establishing the requirements for rate filings.

Section 3 Applicability

This regulation applies to all carriers, as defined in Section 4.D., operating in the State of Colorado. This regulation concerns all health insurance rate filings, including, but not limited to, dental (not covering pediatric dental as an essential health benefit), health coverage plans, limited benefit, long-term care, long-term disability, Medicare supplement, prepaid dental, short-term disability, supplemental health, travel accident/sickness, vision, and excess loss carriers for employers with self-insured health plans, other than health benefit plans. This regulation replaces Emergency Regulation E-13-01 in its entirety.

Section 4 Definitions

A. "Accident only" means, for the purposes of this regulation, coverage for death, dismemberment, disability, or hospital and medical care caused by or necessitated as the result of accident or specified kinds of accident. "Accident Only" policies cannot include 'sickness' or 'wellness' benefits. If additional benefits are provided they must be fully disclosed and properly labeled.

B. "Benefits ratio" means, for the purposes of this regulation, the ratio of policy benefits, not including policyholder dividends, to the value of the earned premiums, not reduced by policyholder dividends, over the entire period for which rates are computed to provide coverage. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits ratio calculations must be displayed without the inclusion of active life reserves.

C. "Carrier" means, for the purposes of this regulation, a carrier as defined in § 10-16-102(8), C.R.S., and includes, but is not limited to, licensed property and casualty insurance companies; licensed life and health insurance companies; non-profit hospital, medical-surgical, and health service corporations; HMOs; prepaid dental companies; and limited service licensed provider networks.

D. "Covered lives" means, for the purposes of this regulation, the number of members, subscribers and dependents.

E. "Disability income policy" means, for the purposes of this regulation, a policy that provides periodic payments to replace income lost when the insured is unable to work as the result of a sickness or injury. Disability income policies cannot include annual doctor visits or outpatient coverage. If additional benefits are provided, they must be fully disclosed and properly labeled. Group disability income policies must comply with § 10-16-214(3)(c), C.R.S. Additional requirements are also addressed under Section 7 of this regulation.

F. "Dividends" means, for the purposes of this regulation, both policyholder and stockholder dividends.

G. "Excessive rates" means, for the purposes of this regulation, rates that are likely to produce a long run profit that is unreasonably high for the insurance provided or if the rates include a provision for expenses that is unreasonably high in relation to the services rendered. In determining if the rate is excessive, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.

H. "File and use" means, for the purposes of this regulation a filing procedure that requires rates and rating data to be filed with the Division of Insurance (Division) concurrent with or prior to distribution, release to producers, collection of premium, advertising, or any

other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. Carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

I. "Filing date" means, for the purposes of this regulation, the date that the rate filing is received at the Division.

J. "Health benefit plan" shall have the same meaning as defined in § 10-16-102(32), C.R.S.

K. "Health coverage plan" shall have the same meaning as defined in § 10-16-102(34), C.R.S. and shall mean a contract, certificate or agreement entered into, offered to, or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For purposes of this regulation, this definition shall not include health benefit plans.

L. "Health care services" shall have the same meaning as defined in § 10-16-102(33), C.R.S.

M. "Hospital indemnity" means, for the purposes of this regulation, a policy that provides a stated daily, weekly or monthly payment while the insured is "hospitalized" regardless of expenses incurred and regardless of whether or not other insurance is in force. Hospital Indemnity policies cannot include medical expense, wellness benefits or well-baby care. If additional benefits are provided they must be fully disclosed and properly labeled.

N. "Implementation date" means, for the purposes of this regulation, the date that the filed or approved rates can be charged to an individual or group.

O. "Inadequate rates" means, for the purposes of this regulation, rates that are clearly insufficient to sustain projected losses and expenses, or if the use of such rates, if continued, will tend to create a monopoly in the marketplace. In determining if the rate is inadequate, the commissioner may consider profits, dividends, annual rate reports, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing.

P. "Lifetime loss ratio", for the purposes of this regulation:

1. "Lifetime loss ratio" is equal to:

a. The sum of the accumulated value of policy benefits from the inception of the policy form(s) to the end of the experience period and the present value of expected policy benefits over the entire future period for which the proposed rates are expected to provide coverage; divided by:

b. The sum of the accumulated value of earned premiums from the inception of the policy form(s) to the end of the experience period and the present value of expected earned premium over the entire future period for which the proposed rates are expected to provide coverage.

2. The lifetime loss ratio should be calculated on an incurred basis as the ratio of accumulated and expected future incurred losses to accumulated and expected future earned premiums. Note: active life reserves do not represent claim payments, but provide for timing differences. Benefits or loss ratio calculations must be displayed without the inclusion of active life reserves.

3. An appropriate rate of interest should be used in calculating the accumulated values and the present values of incurred losses and earned premiums.

4. Any policy form or forms for which the benefits ratio in any policy duration is expected to differ more than 10% from the lifetime loss ratio shall be assumed to have been priced on a “lifetime loss ratio standard”, for purposes of this regulation.

Q. “Limited benefit health plans” means, for the purposes of this regulation, a policy, contract or certificate issued or offered on a group or individual basis as a supplemental health coverage policy that pays specified amounts according to a schedule of benefits to defray the costs of care, services, deductibles copayments or coinsurance amounts not covered by a health benefit plan. Limited benefit health plans do not include short-term limited duration health benefit policies, contracts or certificates; high deductible plans; or catastrophic health policies, contracts or certificates. Such non-supplemental plans are included under the term “health benefit plan”.

R. “New policy form or product” means, for the purposes of this regulation, a policy form that has "substantially different new benefits” or unique characteristics associated with risk or cost that are different from existing policy forms. For example: A guaranteed issue policy form is different than an underwritten policy form, a managed care policy form is different than a non-managed care policy form, a direct written policy form is different from a policy sold using producers, etc.

S. “Non-developed rates” means, for the purposes of this regulation, rates that are established by agreement with a governmental entity through a bidding process or by some other means and include, but are not limited to: rates for Medicare, Title XVIII of the federal “Social Security Act;” Medicaid, Title XIX of the federal “Social Security Act;” and the State Children’s Health Insurance Program (SCHIP), Title XXI of the federal “Social Security Act.”

T. “On-rate-level premium” means, for the purposes of this regulation, the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

U. “Plan” means, for the purposes of this regulation, the specific benefits and cost-sharing provisions available to a covered person.

V. "Premium" means, for purposes of this regulation, the amount of money paid by the insured member, subscriber, or policyholder as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

W. "Prior approval" means, for the purposes of this regulation, a filing procedure that requires a rate change to be affirmatively approved by the commissioner prior to: distribution, release to agents, collection of premium, advertising, or any other use of the rate. Under no circumstance shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing. The implementation date must be at least sixty (60) days after the date of submission. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

X. "PPACA" or "ACA" means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

Y. "Product(s)" means, for the purposes of this regulation, the services covered as a package under a policy form by a carrier, which may have several cost-sharing options and riders as options.

Z. "Qualified actuary" shall meet the requirements outlined in Colorado Insurance Regulation 1-1-1.

AA. "Rate" means, for purposes of this regulation, the amount of money a carrier charges as a condition of providing health care coverage. The rate charged normally reflects such factors as the carrier's expectation of the insured's future claim costs, and the insured's share of the carrier's claim settlement, operational and administrative expenses, and the cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the contract. Rates for all heath coverages must be filed with the Division.

AB. "Rate filing" means, for purposes of this regulation, a filing that contains all of the items required in this regulation, and:

1. For individual products, the proposed base rates and all rating factors, the underlying rating assumptions must be submitted. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of trend factors. Support for new product offerings must be provided; and

2. For group products, proposed base rates, the underlying rating factors and assumptions. Support for all changes in existing rates, factors and assumptions must be provided, including the continued use of trend factors. Support for new

product offerings must be provided. Groups must meet the definition as “valid groups” as defined by Colorado law in § 10-16-214, C.R.S.

AC. “Rate increase” shall have the same meaning as defined in § 10-16-102(57), C.R.S., and includes increases in any current rate or any factor, including trend factors, used to calculate premium rates for new or existing policyholders, members or certificate holders. Rate changes applicable to new business only are considered ‘rate changes, and must be supported. Rate increases for new business only are subject to prior approval.

AD. “Rating Period” shall have the same meaning as defined in § 10-16-102(58), C.R.S.

AE. “Renewed" means, for the purposes of this regulation, a health coverage plan that is deemed renewed upon the occurrence of the earliest of: the annual anniversary date of issue; or the date on which premium rates can be or are changed according to the terms of the plan; or the date on which benefits can be or are changed according to the terms of the plan. If the health care coverage contract specifically allows for a change in premiums or benefits due to changes in state or federal requirements and a change in the health coverage plan premiums or benefits that is solely due to changes in state or federal requirements is not considered a renewal in the health care coverage contract, then such a change will not be considered a renewal for the purposes of this regulation.

AF. “Retention” means, for the purposes of this regulation, the sum of all non-claim expenses including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses as percentage of total premium (or 100% minus the lifetime loss ratio, for products priced on a lifetime loss ratio standard).

AG. “Specified disease coverage” means, for the purposes of this regulation, payment of benefits for the diagnosis and treatment of a specifically named disease or diseases. Medical conditions resulting from accidents are not diseases, and cannot be included.

AH. "Substantially different new benefit” means for the purposes of this regulation, a new benefit that results in a change in the actuarial value of the existing benefits by 10% or more. The offering of additional cost sharing options (i.e. deductibles and copayments) to what is offered as an existing product , does not create a new form. Actuarial value is the change in benefit cost as developed when making other benefit relativity adjustments.

AI. “Trend” or “trending” means, for the purposes of this regulation, any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing. Trend used solely for restating historical experience from the experience period to the rating period, or that is used to project morbidity, is considered a rating assumption.

AJ. “Trend factors” means, for purposes of this regulation, rates or rating factors which vary over time or due to the duration that the insured has been covered under the policy or certificate, and that reflect any of the components of medical or insurance trend assumptions used in pricing. Medical trend includes changes in unit costs of medical services or procedures, medical provider price changes, changes in utilization (other than due to advancing age), medical cost shifting, and new medical procedures and

technology. Insurance trend includes the effect of underwriting wearoff, deductible leveraging, and antiselection resulting from rate increases and discontinuance of new sales. Trend factors include inflation factors, durational factors and the Index Rate for small group business. Rate filings must be submitted on an annual basis to support the continued use of trend factors.

AK. "Underwriting wearoff" means, for the purposes of this regulation, the gradual increase from initial low expected claims that result from underwriting selection to higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

AL. "Unfairly discriminatory rates" means, for the purposes of this regulation, charging different rates for the same benefits provided to individuals, or groups, with like expectations of loss; or if after allowing for practical limitations, differences in rates fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory solely if different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

AM. "Use of the rates" means, for the purposes of this regulation, the distribution of rates or factors to calculate the premium amount for a specific policy or certificate holder including advertising, distributing rates or premiums to agents, and disclosing premium quotes. Rates must be filed with the Division and forms must be certified prior to use. It does not include releasing information about the proposed rating change to other government entities or disclosing general information about the rate change to the public.

AN. "Valid group" shall have the same meaning as defined in § 10-16-214(1), C.R.S. All groups must meet the qualifications as "valid groups". Non-employer groups, including, but not limited to, associations, trusts, unions, and organizations eligible for group life insurance shall be submitted to the Division for approval. Groups formed for the purpose of insurance are prohibited under Colorado law. Multi-state associations must also meet the requirements under § 10-16-214(1), C.R.S. Bona fide associations must meet the requirements under § 10-16-102(6), C.R.S. Trusts must meet the requirements under § 10-7-201, C.R.S., and must be formed by one or more employers or by one or more labor unions, or by one or more employers and one or more labor unions. Union agreements must also be submitted to the Division.

AO. "Wellness and prevention program" shall have the same meaning as defined in § 10-16-136(7)(b), C.R.S., and apply to individual and small group health coverage plans.

Section 5 General Rate Filing Requirements

All rates associated with health coverage policies, riders, contracts, endorsements, certificates, and other evidence of health coverage, must be filed with the Division prior to issuance or delivery of coverage. All rate filings shall be submitted electronically by licensed entities. Failure to supply the information required in Sections 5, 6 and 7 of this regulation will render the filing incomplete. Incomplete filings are not reviewed for substantive content. All filings that are not returned or disapproved on or before the 30th calendar day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be

identified and communicated to the filing carrier on or before the 45th calendar day after receipt. Correction of any deficiency, including deficiencies identified after the 45th calendar day, will be required on a prospective basis, and no penalty will be applied for a non-willful violation identified in this manner. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

A. General Requirements

1. Prior Approval: Any proposed rate increase for other than dental insurance or a rate increase of 5% or more annually for dental insurance, which is effective on or after January 1, 2009, is subject to prior approval by the commissioner and must be filed with the Division at least sixty (60) calendar days prior to the proposed implementation or use of the rates.

    a. If the commissioner approves the rate filing within sixty (60) calendar days after the filing date, the carrier may use the rates immediately upon approval; however, under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date specified in the rate filing.

    b. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division would take appropriate action as defined by Colorado law.

    c. After the rate filing has been approved by the commissioner, carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change.

    d. If the commissioner does not approve or disapprove the rate filing within sixty (60) calendar days after the submission date, the carrier may implement the rates filed.

    e. Under no circumstances shall the carrier provide insurance coverage under the filed rates until on or after the proposed implementation date specified in the rate filing.

2. Existing law also defines a rate increase as any increase in the current rate, including an increase in any base rate, or any rating factor, or continued use of trend factors, used to calculate premium rates, that results in an overall increase in the current rate to any existing policyholder or certificate holder renewing during the proposed rating period of the filing would be considered a prior approval filing. Rate increases as applied to new business only are also subject to prior approval.

    To determine prior approval, calculations should reflect both the 12-months cumulative impact of trend and any changes to rating factors or base rates. Calculations should not reflect a particular policyholder’s movement within each rating table (i.e., change in family status, move to a new region, etc.). Trend

factors do not renew automatically and must be filed annually. Any continued use of any trend factor for more than 12 months is subject to prior approval.

The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a rate filing. Corrections of any deficiency identified after the 60th calendar day will be required on a prospective basis and no penalty will be applied for a non-willful violation identified in this manner if the rates are determined to be excessive, inadequate or unfairly discriminatory.

Rates for Medicare supplement insurance are subject to prior approval as specified in Colorado Insurance Regulation 4-3-1, but are not subject to the 60 day filing requirement of this paragraph.

All filings must be filed with the Rates and Forms Section of the Division. The commissioner shall disapprove the rate filing if any of the following apply:

a. The benefits provided are not reasonable in relation to the premiums charged;

b. The rate filing contains rates that are excessive, inadequate, unfairly discriminatory, or otherwise does not comply with the provisions of Sections 5, 6 and 7 of this regulation. In determining if the rate is excessive or inadequate, the commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice;

c. The actuarial reasons and data do not justify the requested rate increase;

d. The rate filing is incomplete; or

e. The data in the filing failed to adequately support the proposed rates.

3. File and Use: Any rate filing not specified in Paragraph 1 of this subsection is classified as file and use. Existing law allows for file and use rate filings to be implemented upon submission to the Division and correction of any deficiency shall be on a prospective basis. All filings not returned on or before the thirtieth (30^{th}) day after submission to the Division will be considered complete. Rates for all health coverages must be filed with the Division prior to use.

To determine file and use, calculations should reflect the twelve (12) months accumulative impact of trend and any changes to rating factors or base rates. If there is an annual cumulative decrease in rates for all policyholders during the filed rating period then the filing would be file and use.

If new rates, rating factors, or a rate change has been implemented or used without being filed with the Division, corrective actions may be ordered, including, but are not limited to, civil penalties, refunds to policyholders, and/or rate credits. Use of unfiled rates may also be deemed excessive. Under no circumstances shall the carrier provide insurance coverage under the rates until on or after the proposed implementation date. A carrier who provides insurance coverage under the rates before the proposed implementation date will be considered as using unfiled rates and the Division would take appropriate action as defined by Colorado law. Carriers may bill members but not require the member to remit premium prior to the proposed implementation date of the rate change. All filings must be filed with the Rates and Forms Section of the Division.

4. New Policy Forms and Products: Carriers shall not represent an existing product to be a new policy form or product unless if fits the definition set forth in Section 4.S. If a policy form is not a new policy form or product and the rate is increasing, the rate filing will be considered a prior approval filing and the required supporting documentation required by law and regulation will need to be submitted with the filing. If an existing policy form is modified, and it is truly not a new policy form or product, the policy form must be revised to comply with the reasonable modifications provisions of § 10-16-105.1, C.R.S.

5. Non-Developed Rates: Non-developed rates are not subject to the filing requirements of Sections 5, 6 and 7 of this regulation.

6. Required Submissions.

   a. Rates on all health insurance policies, riders, contracts, endorsements, certificates, and other evidence of health care coverage, must be filed with the Division prior to issuance or deliverance of coverage.

   b. All carriers must submit a compliant rate filing whenever the rates charged to new or renewing policyholders or certificate holders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology, or change(s) in the trend or other rating assumptions. Failure to file a rate filing that is compliant with this regulation in these instances will render the carrier as using unfiled rates and the Division will take appropriate action as defined by Colorado law.

   c. All carriers must submit a compliant rate filing on at least an annual basis, at a minimum, to support the continued use of trend factors which change on a predetermined basis. The rate filing must contain detailed support as to why the assumptions upon which the trend factors are based continue to be appropriate. The rate filing shall contain all of the items required in this regulation. The rate filing must demonstrate that the proposed rate the carrier is proposing to use is not excessive, inadequate or unfairly discriminatory. Note: Trend factors which change on a predetermined basis can be continued for no more than period of twelve (12) months. To continue the use of trend factors that change on

a predetermined basis, a filing must be made for that particular form with an implementation date on or before the one-year anniversary of the implementation date of the most recent rate filing.

d. All carriers must submit a compliant rate filing when the rates are changed on an existing product even though the rate change pertains to new business only. Colorado experience data for this existing product must be submitted. If Colorado data is partially credible, nationwide data must also be submitted. Detailed support must be provided for the rate change. Support must also be provided to ensure rates are not discriminatory. Assessing different rates for the same product based on issue dates may violate Colorado law.

e. All carriers must submit a compliant rate filing within sixty (60) calendar days after commissioner approval of the assumption or acquisition of a block of business. This rate filing should provide detailed support for the rating factors the assuming or acquiring carrier is proposing to use, even if there is no change in the rating factors. The new filing must demonstrate that the rating assumptions are still appropriate.

f. Each line of business requires a separate rate filing. Rate filings should not be combined with form filings.

g. All carriers are expected to review their experience on a regular basis, no less than annually, and file rate revisions, as appropriate, in a timely manner to ensure that rates are not excessive or inadequate and to avoid filing large rate changes.

h. The Form Schedule tab in SERFF must be completed for all rate and form filings. This tab must list policies, riders, endorsements, or certificates referenced in the rate filing. Do not attach actual forms in a rate filing.

7. Withdrawn, Returned, or Disapproved Filings: Filings that have either been withdrawn by the filer, returned by the Division as incomplete or disapproved as unjustified, and are subsequently are resubmitted, will be considered as new filings. If a filing is withdrawn, returned, or disapproved, those rates may not be used or distributed. Nothing in this regulation shall render a rate filing subject to prior approval by the commissioner that is not otherwise subject to prior approval as provided by statute.

8. Submission of Rate Filings: All health, sickness and accident insurance (Title 10, Article 16), health care coverage (Title 10, Article 16), Medicare supplement insurance (Title 10, Article 18), long-term care insurance (Title 10, Article 19), and health excess loss insurance (Title 10, Article 16) rate filings must be filed electronically in a format made available by the Division, unless exempted by rule for an emergency situation as determined by the commissioner. If the carrier fails to comply with these requirements, the carrier will be notified that the filing has been returned as incomplete. Complete electronically submitted rate filings must

meet all relevant general requirements, including all necessary rate and policy forms. If a filing is returned as incomplete those rates may not be used or distributed.

9. Carrier Specific: A separate filing must be submitted for each carrier. A single filing, which is made for more than one carrier or for a group of carriers, is not permitted. This applies even if a product is comprised of components from more than one carrier, such as an HMO/indemnity point-of-service plan.

10. Required Inclusions: Rate filings require the submission of an actuarial memorandum in the format as specified under Section 6 of this regulation. A response must be provided for each element under Section 6. The level of detail and the degree of consistency incorporated in the experience records of the carrier are vital factors in the presentation and review of rate filings. Every rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid carrier experience should be used whenever possible. This information may include the carrier's experience and judgment; the experience or data of other carriers or organizations relied upon by the carrier; the interpretation of any statistical data relied upon by the carrier; descriptions of methods used in making the rates; and any other similar information deemed necessary by the carriers. Actual experience must be submitted for changes to existing products. In addition, the commissioner may request additional information used by the carrier to support the rate change request.

11. Confidentiality: All rate filings submitted shall be considered public and shall be open to public inspection, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. The Division does not consider such items as rates, rating factors, rate histories, or side-by-side comparisons of rates or retention components to be confidential. The entire filing, including the actuarial memorandum, cannot be held as confidential. There should be a separate SERFF component for the confidential exhibits, and must be indicated by the icon as confidential in SERFF. Non-confidential information, such as the actuarial memorandum, must be in a separate SERFF component.

    A "Confidentiality Index" must be completed if the carrier desires confidential treatment of any information submitted as required in this regulation. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the carrier if the request for confidentiality is rejected. It should be noted that HMOs are not afforded automatic confidential treatment of any rate filings and therefore must complete a Confidentiality Index.

B. Actuarial Certification

Each rate filing shall include a signed and dated statement by a qualified actuary, which attests that, in the actuary's opinion, the rates are not excessive, inadequate or unfairly discriminatory. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H. of Colorado Insurance Regulation 4-3-1. The requirements for the actuarial certification for certain long-term care rate filings can be found in Sections 10.B. and 18.B. of Colorado Insurance Regulation 4-4-1).

C. Stand-alone dental plans that do not provide pediatric dental coverage as mandated by PPACA must include notification language similar to the following at the time of solicitation:

"This policy DOES NOT include coverage of pediatric dental services as required under The Patient Protection and Affordable Care, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152. Coverage of pediatric dental services is available for purchase in the State of Colorado and can be purchased as a stand-alone plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-certified stand-alone dental plan that includes pediatric dental coverage."

Section 6 Actuarial Memorandum

The rate filing must contain an actuarial memorandum. To ensure compliance with this regulation, each of the following sections must be provided in the memorandum in the designated order shown below, or in an alternate template supplied by the Division. A response must be provided for each element under this section. The actuarial memorandum must be attached to the Supporting Documents tab in SERFF, and must be accompanied by a certification signed by, or prepared under the supervision of, a qualified actuary, in accordance with the actuarial certification requirements of this regulation. Do not attach the actuarial memorandum, supporting documents, or actuarial certification to the Rate/Rule tab in SERFF.

A. Summary: The memorandum must contain a summary that includes, but is not limited to, the following:

1. Reason(s) for the rate filing: A statement as to whether or not this is a new product offering, a rate revision to an existing product, which includes rates applicable to new business only, or a new option being added to an existing form. If the filing is a rate revision, the reason for the revision should be clearly stated.

2. Requested rate action: The overall rate increase or decrease amount should be listed.

3. Marketing method (s): A brief description of the marketing method used for the filed form should be listed. (Agency/Broker, Internet, Direct Response, Other)

   If the block is closed, provide the closure date.

4. Premium classification: This section should state all attributes upon which the premium rates vary.

5. Product descriptions: This section should describe the benefits provided by the policy, rider or contract.

6. Policy/Rider or contract: A listing of all policy/rider or contracts impacted by the submission (for standardized Medicare supplement, the plans should be identified).

7. Age basis: This section must state whether the premiums will be charged on an issue age, attained age, renewal age or other basis and the issue age range of the form should be specified.

8. Renewability provision: A statement regarding the renewability provision and whether the policy/rider is guaranteed renewable, cancellable, non-cancellable, or optionally renewable.

A. SUMMARY	
1. Reason(s). Detail the reason for the filing: New product offering, a rate revision, change in rating methodology, change in benefits, trend only, etc.	
2. Requested Rate Action (This data should agree with the Rate/Rule tab in SERFF):	**Rate Change Without Trend Factor: _____%** **Trend Factor applied*: _____%** **Rate Change With Trend Factor: _____%** **Minimum Change: _____%** **Maximum Change: _____%** ***Trend 'assumptions' used to project morbidity are NOT considered a rate change.**
3. Marketing method(s): **Market Type:**	☐ **Agency / Broker** ☐ **Internet** ☐ **Direct Response** ☐ **Other:** ☐ **Closed Block _____ (Date Closed)** ☐ **Individual** ☐ **Group** ☐ **Small** ☐ **Large** ☐ **Small and Large** ☐ **Employer Only** ☐ **Non-Employer: Identify ALL non-employer Groups, and provide the SERFF Tracking Number of Division Approval** ☐ **Trust: _____** ☐ **Blanket: _____** ☐ **Union: _____** ☐ **Association: _____** _____ _____
4. Premium Classification(s):	☐ **Age** ☐ **Area Factor** ☐ **Gender** ☐ **Smoking and/or Tobacco** ☐ **Group Size Factor** ☐ **Tiers (describe)_____** ☐ **Other _____**
5. Product Description(s):	

6. Policy/Rider impacted:	**Base Policy #** _____ **Rider #** _____ **Rider #** _____ **Rider #** _____ **Rider #** _____ **Rider #** _____ **Rider #** _____
7. Age Basis:	☐ **Issue Age** ☐ **Renewal Age** ☐ **Attained Age** ☐ **Both Issue & Attained Age** ☐ **Other:** _____
8. Renewability Provision	☐ **Guaranteed Renewable** ☐ **Cancellable** ☐ **Non-cancellable** ☐ **Optionally renewable** ☐ **Other**
Additional Information:	

B. Assumption, Acquisition or Merger: The memorandum must state whether or not the products included in the rate filing are part of an assumption, acquisition or merger of policies from/with another carrier. If so, then the memorandum must include the full name of the carrier/carriers from which the policies were assumed, acquired or merged, and the closing date of the assumption, acquisition or merger, and the SERFF Tracking Number of the assumption of the acquisition or assumption rate filing. Commissioner approval of the assumption or acquisition of a block of business is required. See Section 5.A.(6)(e) for acquisition or assumption rate filing requirements.

B. ASSUMPTION, MERGER OR ACQUISITION	
1. Is product part of assumption, acquisition, or merger (from or with another company)?	
Assumption:	☐ **Yes** ☐ **No**
Acquisition:	☐ **Yes** ☐ **No**
Merger:	☐ **Yes** ☐ **No**
2. If yes, provide name of company(s):	
3. Closing Date of assumption, merger or acquisition:	
4. SERFF or State Tracking Number of Assumption rate filing	
Additional Information:	

C. Rating Period: The memorandum must identify the period for which the rates will be effective. At a minimum, the proposed implementation date of the rates must be provided. If the length of the rating period is not clearly identified, it will be assumed to be for twelve months, starting from the proposed implementation date.

C. RATING PERIOD

Proposed Effective Date: (This date must agree with the Implementation Date Requested field reflected on the General Information tab in SERFF.)	**(MM/DD/YYYY)**
Rating Period:	

D. Underwriting: The memorandum must include a brief description of the extent to which this product will be underwritten, if a new product, or the changes, if any, to the underwriting standards, if an existing product. The memorandum should include the expected impact on the claim costs by duration and in total. The carrier shall state separately the effects of different types of underwriting: medical, financial or other. An example of an acceptable brief description is: "This policy form is subject to limited underwriting with yes/no questions. The expected impact is: duration 1 = .15; duration 2 = .05; duration 3 = .03 decrease in claim costs." Underwriting rate ups are considered rating factors and need to be filed and supported – see paragraph Q., "Other Factors", in this section.

E. Effect of Law Changes: The memorandum should identify, quantify, and adequately support any changes to the rates, expenses, and/or medical costs that result from changes in federal, state or local law(s) or regulation(s). All applicable benefit mandates should be listed, including those with no rating impact. This quantification must include the effect of specific mandated benefits and anticipated changes both individually by benefit, as well as for all benefits combined.

E. EFFECT OF LAW CHANGES - Identify and quantify changes resulting from mandated benefits and other law changes.	
Mandated Benefits:	☐ **Yes** ☐ **No**
Other Law Changes:	☐ **Yes** ☐ **No**
Additional information:	

F. Rate History: The memorandum must include a chart showing, at a minimum, all rate changes that have been implemented in the three (3) years immediately prior to the filing date, including the implementation date of each rate change.

1. This chart must contain the following information: the filing number (State or SERFF tracking number), the implementation date of each rate change, the average increase or decrease in rate, the minimum and maximum increase and cumulative rate change for the past twelve (12) months.

2. This chart must contain the cumulative effect of all renewal rates on all rate filings, submitted in the prior year.

3. The rate history should be provided on both a Colorado basis, as well as an average nationwide basis, if applicable. This information must be provided in the format required by the Division.

F. RATE HISTORY					
Provide the State Tracking Number or SERFF Tracking Number of the Previous Rate Filing _____ and Effective Date: _____(MM/DD/YYYY) **Provide rate changes made in at least the last three (3) years** **☐ N/A (Initial Filing)**					
COLORADO					
State Tracking Number or SERFF Tracking Number	**Effective Date**	**% OF CHANGE**			
		Minimum	**Average**	**Maximum**	**Cumulative for past 12 Months**
If data is presented in an exhibit, identify the exhibit.					

NATIONWIDE		
Effective Date	**Average % of change**	**Cumulative for past 12 Months**
Additional Information:		

G. Coordination of Benefits: The memorandum must reflect actual loss experience net of any savings associated with coordination of benefits and/or subrogation.

G. COORDINATION OF BENEFITS			
Provides actual loss experience net of any savings:	**☐ Yes**	**☐ No**	**☐ N/A**
Additional Information:			

H. Relation of Benefits to Premium: The memorandum must adequately support the reasonableness of the relationship of the projected benefits to projected earned premiums for the rating period. This relationship will be presumed to be reasonable if the carrier complies with the following:

1. Medicare Supplement and Long-Term Care Policies: See Section 7.E and 7.F of this regulation.

2. Retention Percentage: The actuarial memorandum must list and adequately support each specific component of the retention percentage. The support for a health benefit plan must include a comparison of the most recent levels experienced for each component as shown in the plan's financial statements,

with an explanation for any variations between retention loads used and actual experience for each component.

a. If the product was not initially priced using a lifetime loss ratio standard, the retention percentage is equal to the sum of all non-claim components of the rate including investment income from unearned premium reserves, contract or policy reserves, reserves from incurred losses, and reserves from incurred but not reported losses.

b. If the product was initially priced using a lifetime loss ratio standard, the retention percentage is equal to 1 minus the lifetime loss ratio.

Each of these specific components must be expressed as a percentage of the earned premium, and should sum to the total carrier retention percentage. Each component should reflect the average assumption used in pricing. Ranges for each assumption and flat dollar amounts are not permitted. The component for profit/contingencies should reflect the target load for profit and contingencies, and not the expected results or operating margin.

The commissioner will evaluate each component for reasonableness and consistency with other similar rate filings. Any change in these components from the previous rate filing must be adequately supported. It should be noted that broad groupings of these components are not permitted.

3. Benefits Ratio Guidelines: The commissioner uses these percentages as guidelines for the acceptability of the carrier's targeted benefits ratio or lifetime loss ratio.

a. All rate filings justifying the relationship of benefits to premium using one of these guidelines must list the components of the retention percentage, as defined in Subsection H.2 of this section. The commissioner will evaluate these components for reasonableness. Policy forms priced at, or above, these benefits ratios may be unacceptable, if one or more of the retention components is not supported.

b. The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Benefits Ratio Guidelines:

Accident Only	60%
Dental	60%
Hospital Indemnity	60%
Limited Benefit Plans	60%
Long-Term Disability Income	60%
Short-Term Disability Income	60%

Short Term Limited Duration Individual Health Plans	60%
Specified or Dread Disease	60%
Excess Loss	60%
Travel Accident/Sickness	60%
Vision	60%
Long-Term Care	60%
Group Medicare Supplement	75%
Individual Medicare Supplement	65%

c. For individual products issued to HIPAA eligible individuals the premiums for these products are, at most, two times the premiums for the underlying, underwritten product.

H. Relation of Benefits to Premium		
Description	**Percentage**	**Support**
Commissions		Year 1 _____% Year 2 _____% Year 3 _____% Year 4 _____% Year 5+ _____% Other:
General expenses		
Premium taxes		
Profit/Contingencies		
Investment Income		
PPACA Fees (if applicable)		
Other Fees (explain)		☐ **Initial** ☐ **Annual**
Other (explain)		
Total Retention		

Targeted Loss Ratio: (This number should equal 1 minus the total retention percentage listed above.)	_____**%**
Actual Benefit Ratio: (This number should be based on the Experience Period.)	☐ **Colorado:** _____**%** ☐ **Nationwide:** _____**%**

I. Lifetime Loss Ratio: The memorandum must state whether or not the product was priced initially using a lifetime loss ratio standard. If the product was priced using a lifetime loss ratio standard, then any subsequent rate change request must be based on the same lifetime loss ratio standard unless there has been a material change in assumptions used to price the product including changes in regulations covering the product. Changes to the lifetime loss ratio must be identified and clearly supported. The lifetime loss ratio standard shall consider the effects of investment income.

Any subsequent rate change request shall consider the variance in the expected benefits ratios over the duration of the policy. The rate filing must include the average policy duration in years as of the endpoint of the experience period and the expected benefits ratio, as originally priced, for each year of the experience period.

The rate filing must also include a chart showing actual and expected benefits ratios for both the experience and rating periods. For each year of the experience period the chart must show the actual and expected benefits ratios, and the ratio of these two benefits ratios. For each year of the rating period, the chart must show the projected and expected benefits ratios, and the ratio of these two benefits ratios. It is expected that the carrier is pricing these products to achieve a benefits ratio greater than or equal to the expected benefits ratio for the rating period.

J. Provision for Profit and Contingencies: The memorandum must identify the provision percentage for profit and contingencies, and how this provision is included in the final rate. If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process. Detailed support must be provided for any proposed load in excess of 7%.

J. PROVISION FOR PROFIT AND CONTINGENCIES	
If material, investment income from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported losses must be considered in the ratemaking process.	
1. Provision for Profit and Contingencies:	**% Pre-Federal Income Tax ___ After tax ___**
2. Proposed load in excess of 7% after tax. Provide detailed support:	
Additional information:	

K. Complete Explanation as to How the Proposed Rates were Determined: The memorandum must contain a section with a complete explanation as to how the proposed rates were determined, including all underlying rating assumptions, with detailed support for each assumption. The Division may return a rate filing if support for each rating assumption is found to be inadequate.

This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis, but it must completely explain how the proposed rates were determined. The memorandum must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums.

K. DETERMINATION OF PROPOSED RATES	
Include all underlying rating assumptions, with detailed support for each assumption. This explanation may be on an aggregate expected loss basis or as a per-member-per-month (PMPM) basis.	
1. Explain, in detail, how rates and/or rate changes were developed:	

2. Provide adequate support for all assumptions and methodologies used:	

L. Trend: The memorandum must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported. Trend factors do not renew automatically. Continued use of trend factors must be supported annually.

1. The four most recent years of monthly experience data used to evaluate historical trends should be provided if available. This experience may include data from the plan being rated, or may include data from other Colorado or National business for similar lines of business, product designs, or benefit configurations.

2. Provided loss data for an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, separately presenting the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. Provided claims experience for an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy.

4. Data elements should be aggregated into 12-month annual periods, with yearly "per member, per month" (PMPM) data, and year-over-year PMPM trends listed separately for medical and pharmacy annual experience PMPMs, trends normalized for changes in demographics, benefit changes, and other factors impacting the true underlying trends should be identified. The trend assumptions shall be quantified into two categories, medical and insurance, as defined below:

    a. Medical trend means, for the purposes of this section, the combined effect of medical provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology.

    b. Insurance trend means, for the purposes of this section, ~~is~~ the combined effect of underwriting wearoff, deductible leveraging, and anti-selection resulting from rate increases and discontinuance of new sales. Note: medical trend must be determined or assumed before insurance trend can be determined. Underwriting wearoff means the gradual increase from initial low expected claims that result from underwriting selection to

higher expected claims for later (ultimate) durations. Underwriting wearoff does not apply to guaranteed issue products.

L. TREND	
Itemized trend component	**Trend (%)**
MEDICAL TREND (total)	
Medical provider price increase	
Utilization changes	
Medical cost shifting	
Medical procedures and new technology	
INSURANCE TREND (total)	
Underwriting wear off	
Deductible leveraging	
Anti-selection	
PHARMACEUTICAL TREND (total)	
Price increases	
Utilization changes	
Cost shifting	
Introduction of new brand and generic drugs	
TOTAL AVERAGE ANNUALIZED TREND (required)	
Additional information:	

M. Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three (3) years. Partial credibility shall be based on either the number of life years OR the number of claims over a three (3) year period. Partial credibility must be used if the Colorado data if not fully credible. The formula for determining the amount of partial credibility to assign to the data is the square root (number of life years/full credibility standard) or the square root (number of claims/full credibility standard).

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and the use of such data must be justified.

2. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is the square root {(# life years or claims)/full credibility standard}. The full credibility standard is defined above, and Colorado data must be provided.

3. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

M. CREDIBILITY	
1. Credibility Percentage (Colorado Only): If other, please specify.	_____ **%**
The above credibility percentage is based upon:	☐ **Life Years** ☐ **Claims** ☐ **Other (please specify)**
2. Number of years of data used to calculate above credibility percentage:	
3. Discuss how and if aggregated data meets the Colorado credibility requirement and how the rating methodology was modified for the partially credible data, if applicable.	
Additional Information (including collateral data, if used):	

N. Data Requirements: The memorandum must include, at a minimum, earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least three (3) years.

1. Pharmacy claims data for health benefit plans or an applicable plan that pays on an expense basis should also be shown separately for incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders.

2. National or other relevant data shall be provided in order to support the rates, if the Colorado data is partially credible. Any rate filing involving an existing product is required to provide this information. This includes, but is not limited to: changes in rates; rating factors; rating methodology; trend; new benefit options; or new plan designs for an existing product.

3. If the purpose of the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product, if available. If no experience from the new product is available, experience from a comparable product must be provided, including experience data from other carriers that have been used to support the rates or, the statistical data used in rate development.

4. Support for new policy forms must be provided. If the new policy form is based on an existing policy form, the experience of the existing policy form must be used to support the new policy form, with an explanation as to the benefit differences and the differences in relativity factors between the old and new policy form. The offering of additional cost sharing options (i.e. deductibles or co-payments) does not change the existing form into a “new product”, as defined in this regulation.

5. Rates must be supported by the most recent data available, with as much weight as possible placed upon the Colorado experience. Data used to support the rates must be included in the filing.

   a. For both renewal filings and new business filings, the experience period must include consecutive data no older than nine months prior to the rate effective implementation date.

   b. For new business only filings, the experience period must include consecutive data on the existing product no older than nine (9) months prior to the effective implementation date.

6. The loss data must be presented on an incurred basis, including accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date, both separately and combined. Premiums and/or exposure data must be stated on both an actual and on-rate-level basis. Capitation payments should be considered as claim or loss payments. The carrier should also provide information on how the number of claims was calculated.

N. DATA REQUIREMENTS

Colorado-only basis for at least 3 years. **Include** national, regional or other appropriate basis, if the Colorado data is not fully credible. The experience period must include consecutive data no older than 9 months prior to the effective implementation date.

	COLORADO DATA							
Year*	**Earned Premium**	**Incurred Claims**	**Total Estimated Incurred Claims**	**Estimated IBNR Claims**	**Loss Ratio**	**Average Covered Lives**	**Number of Claims**	**Colorado On Rate Level Premium**
20XX								
20XX								
20XX								
20XX								
20XX								

***This column should be Calendar Year. If fractional year is used, identify period as MM/YYYY – MM/YYYY**

Above data is for: ☐ Existing Product ☐ Comparable Product
☐ Other _____ (please specify)

	OTHER DATA					
Year	**Earned Premium**	**Incurred Claims**	**Total Estimated Incurred Claims**	**Estimated IBNR Claims**	**Average Covered Lives**	**Number of Claims**
20XX						
20XX						
20XX						
20XX						
20XX						

Above data is for: (Check all the apply)	☐ Existing Product ☐ Comparable Product ☐ National ☐ Other (please specify) _____
Experience Period:	**From:** **To:**
Detailed description regarding support used for "New Product Offering":	
Additional Information:	

O. Side-by-Side Comparison: Each memorandum must include a "side-by-side comparison" identifying any proposed change(s) in rates. This comparison should include three columns: the first containing the current rate, rating factor, or rating variable; the second containing the proposed rate, rating factor, or rating variable; and the third containing the percentage increase or decrease of each proposed change(s). If the proposed rating factor(s) are new, the memorandum must specifically state this and provide detailed support for each of the rating factors.

O. SIDE-BY-SIDE COMPARISON ☐ **N/A - New Product only**				
If the proposed rating factor(s) are new, the memorandum must specifically so state, and provide detailed support for each of the factors.				
Description	**Current Rate/ Rating Factor/ Rating Variable**	**Proposed Rate/ Rating Factor/Rating Variable**	**Percentage Increase/ Decrease**	**Detailed Support for Rating Factor Change**
If the above table is not used, please identify the location of the Side-by-Side Comparison in the rate filing:				
Description and detailed support for new rating factor(s):				
Additional Information:				

P. Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; listing projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

P. BENEFITS RATIO PROJECTIONS

PROJECTED EXPERIENCE FOR RATING PERIOD			
	Premiums	**Incurred Claims**	**Benefits Ratio**
Projected Experience Without Rate Change:			
Projected Experience With Rate Change:			
If priced using a lifetime loss ratio standard, the above projections should show the projected lifetime loss ratios and should include the entire lifetime of the product(s), or a time frame over which the lifetime loss ratio will be achieved. Above projections include (check only one box):	☐ **Colorado** ☐ **Nationwide** ☐ **Blended CO/Nationwide** ☐ **Other (please specify)**		
Additional Information:			

Q. Other Factors: The memorandum must clearly display or clearly reference all other rating factors and definitions used, including the area factors, age factors, gender factors, etc., and provide support for the use of each of these factors in the new rate filing. The same level of support for changes to any of these factors must be included in all renewal rate filings. In addition, the commissioner expects each carrier to review each of these rating factors every five (5) years, at a minimum, and provide detailed support for the continued use of each of these factors in a rate filing. Gender factors shall not vary for individual health care coverage effective on or after January 1, 2011. See Section 8.C. of this regulation. Note: this requirement does not apply to Medicare supplement coverage.

Q. OTHER FACTORS	
Identify and provide support for other rating factors and definitions, including area factors, age factors, gender factors, etc.:	
Additional Information:	

R. Rating manuals and underwriting guidelines: A rating manual and the underwriting guidelines that affect the calculation of the rates must be submitted to the Division for each new product.

All changes to the rating manual and/or underwriting guidelines must be filed with the Division in an appropriate rate filing. Rating manuals and underwriting guidelines based on an accept/reject basis are not required to be filed. Rate pages and rate manuals must be attached to the Rate/Rule Schedule tab in SERFF. All other documents must be attached to the Supporting Documents tab in SERFF.

S. Actuarial certification: An actuarial certification must be submitted with all rate filings. Actuarial Certification is a signed and dated statement made by a qualified actuary which attests that, in the actuary's opinion, the rates are not excessive, inadequate, or unfairly discriminatory.

Section 7 Additional Rate Filing Requirement by Line of Business

The following subsections set forth the requirements by separate lines of business, which must be complied with in addition to the above general requirements:

A. Individual: Renewal rates for individual health coverage plans shall not be affected by the health status or claims experience of the individual insured. A “claims experience factor”, or any other part of the renewal rate calculation, which is based in whole or in part upon the health status or claims experience of the individual insured is prohibited.

B. Wellness and Prevention Programs: A carrier offering an individual health coverage plan or a small group plan in this state may offer incentives or rewards to encourage the individual or small group and other covered persons under the plan to participate in wellness and prevention programs, pursuant to § 10-16-136, C.R.S., and shall be subject to the following:

1. The incentives or rewards shall be made to all participants in the program and may include, but are not limited to: premium discounts or rebates; modifications to copayment, deductible, or coinsurance amounts; the absence of a surcharge; the value of a benefit that would otherwise not be provided; or a combination of these incentives or rewards.

2. Incentives or rewards provided under the program shall not be based upon the size or composition of the small group.

3. The program shall be voluntary and a penalty shall not be imposed on a covered person or small group for not participating.

4. The carrier shall not use the wellness and prevention programs, or incentives or rewards under such programs, to increase rates or premiums for any individuals or small groups covered by the carrier’s plans.

5. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

    a. Does not shift costs to individuals or small groups that decline to participate in the program; and

    b. Is reasonably related to the program.

6. For wellness and prevention programs providing incentives or rewards which are based upon satisfaction of a standard related to a health risk factor:

    a. The carrier shall provide in each filing proof that the wellness program has been accredited by a nationally recognized nonprofit entity that accredits wellness programs pursuant to § 10-16-136(3.7), C.R.S.;

    b. The carrier shall document that the wellness program is scientifically proven to improve health and that the incentives are not provided based on an individual’s actual health status; and

    c. The carrier shall demonstrate in each filing that the incentive or reward offered under the wellness program:

(1) Does not exceed 20% of the premium; and

(2) Is not a subterfuge for discriminating based upon a health status-related factor.

d. For purposes of small group plans, the incentives or rewards attributable to the individual (and all similarly situated individuals) shall be applied to that individual (and all similarly situated individuals), and shall not be distributed to the entire group.

7. The carrier shall include any information as required by the commissioner to ensure that the filed rates, in conjunction with the incentives and rewards available under the wellness program, are not excessive, inadequate, or unfairly discriminatory.

C. Large Group Health Coverage Plans: Large group health coverage plan contracts are considered to be a negotiated agreement between a sophisticated purchaser and seller. Certain rating variables may vary due to the final results of each negotiation. Each large group rate filing must contain the ranges for these negotiated rating variables, an explanation of the method used to apply these rating variables, and a discussion of the need for the filed ranges. A new rate filing is required whenever a rating variable or a range for a rating variable changes. Each filing should also contain an example of how the large group health rates are calculated. While the final rate charged to the large group may differ from the initial quote, all rating variables must be on file with the Division.

Although it is not necessary to submit a separate rate filing for each large group policy issued, each carrier must retain detailed records for each large group policy issued. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies, experience data on each group insured, including, but not limited to, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, and underwriting profits. All rating factors used in determining the final rate should be identified in the detail material and lie within the range identified in the rate filing on file with the Division. The carrier shall make all such information available for review by the commissioner upon request. All such requests must be made at least three (3) business days prior to the date of review.

The rates for subgroups must be determined in an actuarially sound manner using credible data. The methodology for determining these rates must be on file with the Division and any changes in the methodology must be filed with the Division.

Groups must meet the requirements as ‘valid groups’ under § 10-16-214(1)(a), C.R.S. All ‘non-employer’ groups must be approved by the Division. Detailed support must be provided explaining how each non-employer group meets the requirements of a valid group. Groups formed for the sole purpose of insurance are prohibited.

D. Valid Multi-State Association Groups: To be considered a valid multi-state group, a group shall meet the requirements of § 10-16-214(1)(b) and (2), C.R.S. All associations must be identified and the by-laws and articles of association for each association must be

submitted to the Division for approval. Once the association has been approved by the Division, the filing must provide the SERFF Tracking Number of the approval filing when submitting all rate filings for the association, and include confirmation that the coverage requirements of the association are still being met.

E. Medicare Supplement: A Medicare supplement policy is defined in § 10-18-101(4), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4 3-1 and §§ 10-18-101 to 109, C.R.S. If the requirements of both Colorado Insurance Regulation 4-3-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. Medicare supplement filings require prior approval. (The requirements for the actuarial certification for Medicare supplement rate filings can be found in Section 14.H of Colorado Insurance Regulation 4-3-1. Additional rating requirements can be found in Sections 10.E, 13 and 14.F – J of that same regulation). Although the Modernized plans must be filed separately from the closed OBRA ’90 Standardized plans, the experience for the Modernized plans and the OBRA ’90 Standardized plans must be included in each filing type. The experience must be reported separately by plan for each type, as well as combined by plan for Modernized and Standardized, and totaled as all plans. This must be done for all Colorado plans. Nationwide data must be provided if Colorado data is not fully credible.

F. Long-Term Care: Long-term care insurance is defined in § 10-19-103(5), C.R.S., and regulated pursuant to Colorado Insurance Regulation 4-4-1 and §§ 10-19-101 to 115, C.R.S. If the requirements of both Colorado Insurance Regulation 4-4-1 and this regulation are not met, the filing will be considered incomplete and returned to the carrier. The filing must also:

1. Demonstrate that investment income has been considered in the development of the rate;

2. Provide the expected benefits ratios for both the experience period and the projection period on an annual basis;

3. Provide the ratio of the actual benefits ratio to the expected benefits ratio for each year of the life of the policy on both a durational and calendar year basis; and

4. Provide a discussion as to how the original pricing assumptions have changed historically, and how the assumptions for the future period compare to the original pricing assumptions and the current rating assumptions.

G. Disability Income: The filing must demonstrate that investment income has been considered in the development of the rate. Each must be supported separately. Group disability income plans must also meet the requirements under § 10-16-214(3)(c),C.R.S.

H. Limited Service Licensed Provider Network (LSLPN): Rates and premiums for products issued by an LSLPN are to be determined on a fixed prepayment basis. Therefore, no LSLPN product may be issued on a cost-plus or retrospective rating basis.

Section 8 Prohibited Rating Practices

The commissioner has determined that certain rating activities lead to excessive, inadequate or unfairly discriminatory rates, and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with §§ 10-16-107, 10-16-109, and 10-3-1110(1), C.R.S., the following are prohibited:

A. Attained age premium schedules where the slope by age is substantially different from the slope of the ultimate claim cost curve. However, this requirement is not intended to prohibit use of a premium schedule which provides for attained age premiums to a specific age followed by a level premium, or the use of reasonable step rating;

B. The use of premium modalization factors which implicitly or explicitly increase the premium to the consumer by any amount other than those amounts necessary to offset reasonable increases in actual operating expenses that are associated with the increased number of billings and/or the loss of interest income;

C. For individual health coverage plans other than Medicare supplement, rates shall not vary due to the gender of the individual policyholder, enrollee, subscriber, or member for rates effective on or after January 1, 2011, pursuant to § 10-16-107(1.5)(b), C.R.S; and

D. For individual health insurance plans, other than Medicare supplement, the use of any rating factors based upon zip codes which fail to equitably adjust for different expectations of loss. It is the expectation of the commissioner that areas of the state with like expectations of loss must be treated in a similar manner. Also, policyholders utilizing the same provider groups should be rated in a like manner. The use of zip codes in determining rating factors can result in inequities. Unless different rating factors can be justified based upon different provider groups or other actuarially sound reasons, the following guidelines shall be followed whenever zip codes are used in determining a carrier's rating factors:

    1. All zip codes in the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor, with the following possible exceptions:

        a. The following zip codes in Elbert County: 80101, 80106, 80107, 80117;

        b. The following zip codes in Arapahoe County: 80102, 80103, 80105, 80136;

        c. The following zip codes in El Paso County: 80132, 80133; and

        d. The following zip codes in Boulder County: 80025, 80026, 80027, 80028.

    2. In addition, the following zip codes outside the 800-802 three-digit zip code groups are considered part of the Denver metropolitan area and shall receive the same rating factor as the 800-802 three-digit zip code groups:

        a. The following zip codes in Jefferson County: 80401-80403, 80419, 80433, 80437, 80439, 80453, 80454, 80457, 80465.

b. The following zip codes in Adams County: 80614, 80640.

3. All zip codes in the 809 three-digit zip code group are considered part of the Colorado Springs metropolitan area and shall receive the same rating factor. In addition, the following zip codes in El Paso County, which lie outside the 809 three-digit zip code group shall be considered part of the Colorado Springs metropolitan area and shall receive the same rating factor as the 809 three-digit zip code group: 80809, 80817, 80819, 80829, 80831, 80840, 80841.

If a carrier uses area rating factors which are based in whole or in part upon the zip code, and does not follow these guidelines, the carrier may be found to have rates that are unfairly discriminatory. The commissioner would prefer that a carrier use federal MSA's, rather than zip codes, in their rating structure. The commissioner expects carriers to review the appropriateness of area factors at least every five years and provide detailed support for the continued use of the factors in rate filings and upon request.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective date

This regulation is amended effective October 1, 2013.

Section 12 History

Regulation 4-2-11, effective November 1, 1992.
Regulation Repealed and Re-promulgated, effective February 1, 1999.
Regulation amended effective January 1, 2001.
Regulation amended effective December 1, 2005.
Regulation amended effective December 1, 2007.
Emergency Regulation 08-E-4 was effective July 1, 2008.
Regulation amended effective October 1, 2008.
Regulation amended effective February 1, 2009.
Regulation amended effective July 1, 2009.
Regulation amended effective January 1, 2010.
Regulation 4-2-11 amended, effective May 1, 2010.
Regulation 4-2-11 amended, effective January 1, 2011.
Regulation 4-2-11 amended, effective January 1, 2012.
Regulation 4-2-11 amended, effective February 1, 2013.
Regulation 4-2-11 amended, effective October 1, 2013.